Broward ENT & Aesthetics

Wilson DuMornay, MD, FACS | Maria Espinel, MSN, FNP-BC

Patient Information

Patient Name: _____DOB: _____ Gender F M

Marital status: Single ☐ Married ☐ Divorce ☐ Separated ☐ Widow ☐ Partnered ☐

Address: _____ City: _____ State: _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation/School: _____ Address: _____

Email : _____

Primary Care Physician (Name, Address and Number): _____

_____

Pharmacy (Name, Address and Number) _____

_____

Emergency Contact Information

Emergency contact: _____ Relationship _____ Number:_____

Emergency contact: _____ Relationship _____ Number:_____

Insurance Information

Primary Insurance: _____ Guarantor: _____

ID: _____ Group: _____ Guarantor DOB _____

Secondary Insurance: _____ Guarantor: _____

ID: _____ Group: _____ Guarantor DOB _____

Please hand in insurance card and picture ID when you have completed this form, we need to make a copy for billing purpose

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Wilson DuMornay or insurance company to release any information required to process my claims.

Patient/ Guardian Signature: _____ Date:_____

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Patient History

Hospitalization and Surgeries (reason and date):_____

_____

Past Medical History: (Have you ever had any of the following?)

□Alcoholism	□Allergies	□Anemia	□Anxiety Disorder	□Arthritis
□Asthma	□AIDS/HIV	□Back Problems	□Bleeding Disorder	□Blood Disease
□Blood Transfusion	□Cancer	□Diabetes	□Depression	□Ear Problems
□Eating Disorder	□Epilepsy	□Glaucoma	□Gout	□Heart Disease
□Heart Problems	□Hepatitis –A, B, C	□High Blood Pressure	□High cholesterol	□Joint disorder
□Kidney Disorder	□Liver Disorder	□Lung Disease	□Measles	□Migraines
□Osteoporosis	□Pneumonia	□Polio	□Rheumatic Fever	□Stroke
□Skin Disorder	□Stomach Ulcer	□Substance Abuse	□Thyroid Disorder	□Tuberculosis
□Venereal Disease				

Family History: (has anyone in your family ever had any of the following conditions?)

□Alcoholism	□Allergies	□Alzheimer's	Anemia	□Anxiety Disorder
□Arthritis	□Asthma	□AIDS/HIV	□Back Problems	□Bleeding Disorder
□Blood Transfusion	□Cancer	□Diabetes	□Depression	□Epilepsy
□Genetic Disorder	□Glaucoma	□Gout	□Heart Disease	□Heart Problems
□Hepatitis –A,B,C	□High Blood Pressure	□High cholesterol	□Joint disorder	□Osteoporosis
□Liver Disorder	□Lung Disease	□Measles	□Migraines	□Skin Disorder
□Pneumonia	□Polio	□Rheumatic Fever	□Stroke	
□Stomach Ulcer	□Substance Abuse	□Thyroid Disorder	□Tuberculosis	

Do you have any of the following?

□Headache	□Blurry Vision	□ Hay Fever	□ Hoarseness	□Cough
□Lethargy/ Weakness	□ Vision Halos	□ Nosebleeds	□ Excessive Salivation	□Shortness of breath
□Fatigue	□ Ringing Ears	□ Post-Nasal Drip	□ Mouth Mass	□Coughing up blood
□Fever	□ Pulsation in Ears	□ Runny Nose	□ Tongue Swelling	□Increased Secretions
□Weight Loss	□ Hearing Loss	□ Snoring	□Dry Mouth	□stridor
□Weight Gain	□ Ear Itching	□ Decreased Sense of Smell		□wheeze
□Vertigo	□ Sound Sensitivity	□ Oral Bleeding	□ Dental Caries	□Bleeding
□Dizziness	□ Ear Fullness/Pressure	□ Oral Pain	□ Pain w/ swallowing	□Clots
□Malaise	□ Ear Pain	□ Changes in taste	□Difficulty Swallowing	□Neck Pain
□Night Sweats	□ Ear Drainage	□ Bad Breath	□Indigestion	□Neck Stiffness
□ Double Vision	□Nasal Congestion	□Sore throat/throat pain	□Ulcers	□Neck Mass
□Increased Infections	□Difficulty Breathing when Lying Flat		□Heartburn	

Allergies: Have you ever been allergy tested? □Yes □No When? _____ Have you ever taken allergy shots? □Yes □No When? _____

Are you allergic to any of the following: □Adhesive tape □Antibiotic □Latex □Barbiturates (sleeping pills) □Aspirin

□Sulfa □Local Anesthetics □Shellfish/iodine **Do you have any other allergies**? (Name and Reaction) _____

_____

Do you smoke now? □Yes □No # packs/day ____ Lifestyle Factors: Have you smoked? □Yes □No # of years___ # packs/day_____

Do you use recreational drugs? □Yes □No types? _____ # times/weeks _____

How much alcohol do you drink per week? # drinks/weeks _____

How much caffeine do you drink per day? # drinks/days _____

Have you had the Flu Vaccine □yes □No Height _____ Weight _____

Current medication: are you taking any blood thinners? □Yes □No What medications are you currently taking (Name/Dosage/Frequency):

_____

_____

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PATIENT FINANCIAL POLICY

Valid in insurance cards are to be presented at the time of service. It is the member's responsibility to inform us of any changes to demographic or insurance information.

COPAYMENTS

All copayments are due at the time of service, unless other arrangements have been made. We accept cash, check, and credit/debit cards. There is a $50.00 fee for back returned checks.

SELF-PAY

Self-pay accounts are classified as patients who do not have insurance coverage, or who have an insurance plan that we do not participate with, and or out of network benefits are not available. Patients who are self-pay are expected to pay for the visit in full at the time of service.

REFUNDS

If there is a credit on your account, we will use this credit towards any future balances. In some instances a refund may be due to you from the practice. If this is the case, a refund check will be issued. A check will not be issued under the following circumstances; claim balances due from the patient, outstanding claims with the insurance company, and future appointments on the schedule.

DIVORCE CASES

In the case of divorce, the individual who receives the care is responsible for payment of co-pays, coinsurance, and non-participating insurance balances. We will not bill a divorced spouse for the patient's services.

CHILD CUSTODY CASES

The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance or non-participating insurance. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company. The practice does not get involved with the divorce specifies, (i.e One parent pays 80% and the other pays 20%) It is the parents obligation to work out an agreement themselves or through the court system.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

Patient/Guardian Signature: _____

Print Name: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the health insurance portability & Accountability act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice or Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____

RELEASE OF INFORMATION TO PERSON

This form will allow you to designate and individual(s) to whom Dr. DuMornay's office may disclose your protected health information. This may include individually identifiable information relating to mental health treatment or HIV test results as releasing that information requires your separate written consent.

If you do not want to designate an individual(s) to receive your protected health information, indicate "NONE" below:

Patient Name:_____ Date of Birth _____

I do hereby authorize Dr. Wilson DuMornay's office to disclose protected health information to the following:

1._____

Relationship to patient: _____ Telephone #_____

2._____

Relationship to patient: _____ Telephone #_____

By signing below I acknowledge that I have had full opportunity to read and consider the consent of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude Dr. DuMornay's office from disclosing my protected health information as outlined by the offices Health Privacy Practices.

I understand that I have the option to revoke this authorization at any time at which time I can execute a new authorization. I also understand that unless revoked in writing by completing new authorization form, this authorization will remain in effect until I choose to revoke it.

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth _____

Previous Name _____

I request and authorize _____to release healthcare information of the patient named above to:

Name: Dr Wilson DuMornay_____

Address: 3536 N Federal Hwy Ste 102___

City: Fort Lauderdale_____State: FL_____ Zip Code 33308__

This request and authorization applies to:

□Healthcare information relating to the following treatment, condition, or dates_____
_____

□All healthcare information

□Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, Chancroid, lympho granuloma Venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□yes □no I authorize the release of my STD results, HIV/Aids testing, whether negative or positive, to the person listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□yes □no I authorize the release of any records regarding drug, alcohol, or mental health treatment to the Person(s) listed above.

Patient signature: _____ Date Signed:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

IF MORE THAN 25 PAGES PLEASE MAIL.